

(f) *Other educational programs.* There may also be other educational programs not included in the foregoing in which a provider institution is engaged. Appropriate consideration will be given by the intermediary and HCFA to the costs incurred for those activities that come within the purview of the principle when determining the allowable costs for apportionment under the Medicare program.

(g) *Calculating net cost.* Net costs of approved educational activities are determined by deducting, from a provider's total costs of these activities, revenues it receives from tuition. For this purpose, a provider's total costs include trainee stipends, compensation of teachers, and other direct and indirect costs of the activities as determined under the Medicare cost-finding principles in §413.24.

(h) *Medicare+Choice organizations.* (1) Effective January 1, 1999, Medicare+Choice organizations may receive direct graduate medical education payments for the time that residents spend in nonhospital provider settings such as freestanding clinics, nursing homes, and physicians' offices in connection with approved programs.

(2) Medicare+Choice organizations may receive direct graduate medical education payments if all of the following conditions are met:

(i) The resident spends his or her time in patient care activities.

(ii) The Medicare+Choice organization incurs "all or substantially all" of the costs for the training program in the nonhospital setting as defined in §413.86(b).

(iii) There is a written agreement between the Medicare+Choice organization and the nonhospital site that indicates the Medicare+Choice organization will incur the costs of the resident's salary and fringe benefits and provide reasonable compensation to the nonhospital site for teaching activities.

(3) A Medicare+Choice organization's allowable direct graduate medical education costs, subject to the redistribution and community support principles in §413.85(c), consist of—

(i) Residents' salaries and fringe benefits (including travel and lodging where applicable); and

(ii) Reasonable compensation to the nonhospital site for teaching activities related to the training of medical residents.

(4) The direct graduate medical education payment is equal to the product of—

(i) The lower of—

(A) The Medicare+Choice organization's allowable direct graduate medical education costs per resident as defined in paragraph (h)(3) of this section; or

(B) The national average per resident amount; and

(ii) Medicare's share, which is equal to the ratio of the number of Medicare beneficiaries enrolled to the total number of individuals enrolled in the Medicare+Choice organization.

(5) Direct graduate medical education payments made to Medicare+Choice organizations under this section are made from the Federal Supplementary Medical Insurance Trust Fund.

[51 FR 34793, Sept. 30, 1986, as amended at 54 FR 40315, Sept. 29, 1989; 63 FR 41005, July 31, 1998]

§413.86 Direct graduate medical education payments.

(a) *Statutory basis and scope—*(1) *Basis.* This section implements section 1886(h) of the Act by establishing the methodology for Medicare payment of the cost of direct graduate medical educational activities.

(2) *Scope.* This section applies to Medicare payments to hospitals and hospital-based providers for the costs of approved residency programs in medicine, osteopathy, dentistry, and podiatry for cost reporting periods beginning on or after July 1, 1985.

(b) *Definitions.* For purposes of this section, the following definitions apply:

Affiliated group means—

(1) Two or more hospitals located in the same urban or rural area (as those terms are defined in §412.62(f) of this subchapter) or in contiguous areas if individual residents work at each of the hospitals during the course of the program; or

(2) If the hospitals are not located in the same or a contiguous urban or

rural area, the hospitals are jointly listed—

(i) As the sponsor, primary clinical site or major participating institution for one or more of the programs as these terms are used in *Graduate Medical Education Directory, 1997-1998*; or

(ii) As the sponsor or under “affiliations and outside rotations” for one or more programs in operation in *Opportunities, Directory of Osteopathic Postdoctoral Education Programs*.

(3) The hospitals are under common ownership.

All or substantially all of the costs for the training program in the nonhospital setting means the residents’ salaries and fringe benefits (including travel and lodging where applicable) and the portion of the cost of teaching physicians’ salaries and fringe benefits attributable to direct graduate medical education.

Approved geriatric program means a fellowship program of one or more years in length that is approved by one of the national organizations listed in §415.152 of this chapter under that respective organization’s criteria for geriatric fellowship programs.

Approved medical residency program means a program that meets one of the following criteria:

(1) Is approved by one of the national organizations listed in §415.152 of this chapter.

(2) May count towards certification of the participant in a specialty or subspecialty listed in the current edition of either of the following publications:

(i) The Directory of Graduate Medical Education Programs published by the American Medical Association, and available from American Medical Association, Department of Directories and Publications, 515 North State Street, Chicago, Illinois 60610; or

(ii) The Annual Report and Reference Handbook published by the American Board of Medical Specialties, and available from American Board of Medical Specialties, One Rotary Center, suite 805, Evanston, Illinois 60201.

(3) Is approved by the Accreditation Council For Graduate Medical Education (ACGME) as a fellowship program in geriatric medicine.

(4) Is a program that would be accredited except for the accrediting

agency’s reliance upon an accreditation standard that requires an entity to perform an induced abortion or require, provide, or refer for training in the performance of induced abortions, or make arrangements for such training, regardless of whether the standard provides exceptions or exemptions.

Base period means a cost reporting period that began on or after October 1, 1983 but before October 1, 1984.

CPI—U stands for the Consumer Price Index for All Urban Consumers as compiled by the Bureau of Labor Statistics.

Foreign medical graduate means a resident who is not a graduate of a medical, osteopathy, dental, or podiatry school, respectively, accredited or approved as meeting the standards necessary for accreditation by one of the following organizations:

(1) The Liaison Committee on Medical Education of the American Medical Association.

(2) The American Osteopathic Association.

(3) The Commission on Dental Accreditation.

(4) The Council on Podiatric Medical Education.

FMGEMS stands for the Foreign Medical Graduate Examination in the Medical Sciences (Part I and Part II).

FTE stands for full-time equivalent.

Medicare patient load means, with respect to a hospital’s cost reporting period, the total number of hospital inpatient days during the cost reporting period that are attributable to patients for whom payment is made under Medicare Part A divided by total hospital inpatient days. In calculating inpatient days, inpatient days in any distinct part of the hospital furnishing a hospital level of care are included and nursery days are excluded.

Primary care resident is a resident enrolled in an approved medical residency training program in family medicine, general internal medicine, general pediatrics, preventive medicine, geriatric medicine or osteopathic general practice.

Resident means an intern, resident, or fellow who participates in an approved medical residency program, including programs in osteopathy, dentistry, and

podiatry, as required in order to become certified by the appropriate specialty board.

(c) *Payment for graduate medical education costs—General rule.* Beginning with cost reporting periods starting on or after July 1, 1985, hospitals, including hospital-based providers, are paid for the costs of approved graduate medical education programs as described in paragraph (d) through (h) of this section.

(d) *Calculating payment for graduate medical education costs.* A hospital's Medicare payment for the costs of an approved residency program is calculated as follows:

(1) *Step one.* The hospital's updated per resident amount (as determined under paragraph (e) of this section) is multiplied by the actual number of FTE residents (as determined under paragraph (g) of this section). This result is the aggregate approved amount for the cost reporting period.

(2) *Step two.* The product derived in step one is multiplied by the hospital's Medicare patient load.

(3) *Step three.* For portions of cost reporting periods beginning on or after January 1, 1998, the product derived in step one is multiplied by the proportion of the hospital's inpatient days attributable to individuals who are enrolled under a risk-sharing contract with an eligible organization under section 1876 of the Act and who are entitled to Medicare Part A or with a Medicare+Choice organization under Title XVIII, Part C of the Act. This amount is multiplied by an applicable payment percentage equal to—

- (i) 20 percent for 1998;
- (ii) 40 percent for 1999;
- (iii) 60 percent in 2000;
- (iv) 80 percent in 2001; and
- (v) 100 percent in 2002 and subsequent years.

(4) *Step four.* Add the results of steps 2 and 3.

(5) *Step five.* The product derived in step two is apportioned between Part A and Part B of Medicare based on the ratio of Medicare's share of reasonable costs excluding graduate medical education costs attributable to each part as determined through the Medicare cost report.

(e) *Determining per resident amounts for the base period—*(1) *For the base period.* (i) Except as provided in paragraph (e)(4) of this section, the intermediary determines a base-period per resident amount for each hospital as follows:

(A) Determine the allowable graduate medical education costs for the cost reporting period beginning on or after October 1, 1983 but before October 1, 1984. In determining these costs, graduate medical education costs allocated to the nursery cost center, research and other nonreimbursable cost centers, and hospital-based providers that are not participating in Medicare are excluded and graduate medical education costs allocated to distinct-part hospital units and hospital-based providers that participate in Medicare are included.

(B) Divide the costs calculated in paragraph (e)(1)(i)(A) of this section by the average number of FTE residents working in all areas of the hospital complex (including those areas whose costs were excluded under paragraph (e)(1)(i)(A) of this section) for its cost reporting period beginning on or after October 1, 1983 but before October 1, 1984.

(ii) In determining the base-period per resident amount under paragraph (e)(1)(i) of this section, the intermediary—

(A) Verifies the hospital's base-period graduate medical education costs and the hospital's average number of FTE residents;

(B) Excludes from the base-period graduate medical education costs any nonallowable or misclassified costs, including those previously allowed under §412.113(b)(3) of this chapter; and

(C) Upon a hospital's request, includes graduate medical education costs that were misclassified as operating costs during the hospital's prospective payment base year and were not allowable under §412.113(b)(3) of this chapter during the graduate medical education base period. These costs may be included only if the hospital requests an adjustment of its prospective payment hospital-specific rate or target amount as described in paragraph (k)(1) of this section.

(iii) If the hospital's cost report for its GME base period is no longer subject to reopening under §405.1885 of this chapter, the intermediary may modify the hospital's base-period costs solely for purposes of computing the per resident amount.

(iv) If the intermediary modifies a hospital's base-period graduate medical education costs as described in paragraph (e)(1)(ii)(B) of this section, the hospital may request an adjustment of its prospective payment hospital-specific rate or target amount as described in paragraph (k)(1) of this section.

(v) The intermediary notifies each hospital that either had direct graduate medical education costs or received indirect education payment in its cost reporting period beginning on or after October 1, 1984 and before October 1, 1985 of its base-period average per resident amount. A hospital may appeal this amount within 180 days of the date of that notice.

(2) *For cost reporting periods beginning on or after July 1, 1985 and before July 1, 1986.* For cost reporting periods beginning on or after July 1, 1985 and before July 1, 1986, a hospital's base-period per resident amount is adjusted as follows:

(i) If a hospital's base period began on or after October 1, 1983 and before July 1, 1984, the amount is adjusted by the percentage change in the CPI-U that occurred between the hospital's base period and the first cost reporting period to which the provisions of this section apply. The adjusted amount is then increased by one percent.

(ii) If a hospital's base period began on or after July 1, 1984 and before October 1, 1984, the amount is increased by one percent.

(3) *For cost reporting periods beginning on or after July 1, 1986.* For cost reporting periods beginning on or after July 1, 1986, a hospital's base-period per resident amount is adjusted as follows:

(i) Except as provided in paragraph (e)(3)(ii) of this section, each hospital's per resident amount for the previous cost reporting is adjusted by the projected change in the CPI-U for the 12-month cost reporting period. This adjustment is subject to revision during the settlement of the cost report to reflect actual changes in the CPI-U that

occurred during the cost reporting period.

(ii) For cost reporting periods beginning on or after October 1, 1993 through September 30, 1995, each hospital's per resident amount for the previous cost reporting period will not be adjusted for any resident FTEs who are not either a primary care resident or an obstetrics and gynecology resident.

(4) *Exceptions—(i) Base period for certain hospitals.* If a hospital did not have any approved medical residency training programs or did not participate in Medicare during the base period, but either condition changes in a cost reporting period beginning on or after July 1, 1985, the intermediary establishes a per resident amount for the hospital using the information from the first cost reporting period during which the hospital participates in Medicare and the residents are on duty during the first month of that period. Any graduate medical education program costs incurred by the hospital before that cost reporting period are reimbursed on a reasonable cost basis. The per resident amount is based on the lower of the following:

(A) The hospital's actual costs, incurred in connection with the graduate medical education program for the hospital's first cost reporting period in which residents were on duty during the first month of the cost reporting period.

(B) The mean value of per resident amounts of hospitals located in the same geographic wage area, as that term is used in the prospective payment system under part 412 of this chapter, for cost reporting periods beginning in the same fiscal years. If there are fewer than three amounts that can be used to calculate the mean value, the calculation of the per resident amounts includes all hospitals in the hospital's region as that term is used in §412.62(f)(1)(i).

(ii) *Short or long base-period cost reporting periods.* If a hospital's base-period cost reporting period reflects graduate medical education costs for a period that is shorter than 50 weeks or longer than 54 weeks, the intermediary converts the allowable costs for the base period into a daily figure. The daily figure is then multiplied by 365 or

366, as appropriate, to derive the approved per resident amount for a 12-month base-period cost reporting period. If a hospital has two cost reporting periods beginning in the base period, the later period serves as the base-period cost reporting period.

(iii) *Short or long cost reporting periods beginning on or after July 1, 1985.* If a hospital's cost reporting period is shorter than 50 weeks or longer than 54 weeks, the hospital's intermediary should contact HCFA Central Office to receive a special CPI-U adjustment factor.

(f) *Determining the total number of FTE residents.* Subject to the weighting factors in paragraphs (g) and (h) of this section, the count of FTE residents is determined as follows:

(1) Residents in an approved program working in all areas of the hospital complex may be counted.

(2) No individual may be counted as more than one FTE. Except as provided in paragraphs (f)(3) and (4) of this section, if a resident spends time in more than one hospital or, in a nonprovider setting, the resident counts as partial FTE based on the proportion of time worked at the hospital to the total time worked. A part-time resident counts as a partial FTE based on the proportion of allowable time worked compared to the total time necessary to fill a full-time internship or residency slot.

(3) On or after July 1, 1987 and for portions of cost reporting periods occurring before January 1, 1999, the time residents spend in nonprovider settings such as freestanding clinics, nursing homes, and physicians' offices in connection with approved programs is not excluded in determining the number of FTE residents in the calculation of a hospital's resident count if the following conditions are met—

(i) The resident spends his or her time in patient care activities.

(ii) There is a written agreement between the hospital and the outside entity that states that the resident's compensation for training time spent outside of the hospital setting is to be paid by the hospital.

(4) For portions of cost reporting periods occurring on or after January 1, 1999, the time residents spend in non-

provider settings such as freestanding clinics, nursing homes, and physicians' offices in connection with approved programs may be included in determining the number of FTE residents in the calculation of a hospital's resident count if the following conditions are met—

(i) The resident spends his or her time in patient care activities.

(ii) The written agreement between the hospital and the nonhospital site must indicate that the hospital will incur the cost of the resident's salary and fringe benefits while the resident is training in the nonhospital site and the hospital is providing reasonable compensation to the nonhospital site for supervisory teaching activities. The agreement must indicate the compensation the hospital is providing to the nonhospital site for supervisory teaching activities.

(iii) The hospital must incur all or substantially all of the costs for the training program in the nonhospital setting in accordance with the definition in paragraph (b) of this section.

(g) *Determining the weighted number of FTE residents.* Subject to the provisions in paragraph (h) of this section, HCFA determines a hospital's number of FTE residents by applying a weighting factor to each resident and then summing the resulting numbers that represent each resident. The weighting factor is determined as follows:

(1) For purposes of this section, an initial residency period is the number of years necessary to satisfy the minimum requirements for certification in a specialty or subspecialty, plus one year. Effective August 10, 1993, residents or fellows in an approved preventive medicine residency or fellowship program may also be counted as a full FTE resident for up to two additional years beyond the initial residency period limitations. Effective July 1, 1995, an initial residency period is defined as the minimum number of years required for board eligibility. An initial residency period may not exceed five years in order to be counted toward determining FTE status except in the case of fellows in an approved geriatric program whose initial residency period may last up to two additional years. For combined residency programs, an

initial residency period is defined as the time required for individual certification in the longer of the programs. If the resident is enrolled in a combined medical residency training program in which all of the individual programs (that are combined) are for training primary care residents (as defined in paragraph (b) of this section) or obstetrics and gynecology residents, the initial residency period is the time required for individual certification in the longer of the programs plus one year.

(i) For residency programs other than those specified in paragraphs (g)(1)(ii) and (g)(1)(iii) of this section, the initial residency period is the minimum number of years of formal training necessary to satisfy the requirements for initial board eligibility in the particular specialty for which the resident is training, as specified in the most recently published edition of the Graduate Medical Education Directory.

(ii) For residency programs in osteopathy, dentistry, and podiatry, the minimum requirement for certification in a specialty or subspecialty is the minimum number of years of formal training necessary to satisfy the requirements of the appropriate approving body listed in §415.152 of this chapter.

(iii) For residency programs in geriatric medicine, accredited by the appropriate approving body listed in 415.152 of this chapter, these programs are considered approved programs on the later of—

(A) The starting date of the program within a hospital; or

(B) The hospital's cost reporting periods beginning on or after July 1, 1985.

(iv) The time spent in residency programs that do not lead to certification in a specialty or subspecialty, but that otherwise meet the definition of approved programs, as described in paragraph (b) of this section, is counted toward the initial residency period limitation.

(2) If the resident is in an initial residency period, the weighting factor is one.

(3) If the resident is not in an initial residency period, the weighting factor is 1.00 during the period beginning on or after July 1, 1985 and before July 1, 1986, .75 during the period beginning on

or after July 1, 1986 and before July 1, 1987 and is .50 thereafter without regard to the hospital's cost reporting period.

(4) For purposes of determining direct graduate medical education payment, for cost reporting periods beginning on or after October 1, 1997, a hospital's unweighted FTE count for residents in allopathic and osteopathic medicine may not exceed the hospital's unweighted FTE count for these residents for the most recent cost reporting period ending on or before December 31, 1996. If the hospital's number of FTE residents in a cost reporting period beginning on or after October 1, 1997, exceeds the limit described in this paragraph (g), the hospital's weighted FTE count (before application of the limit) will be reduced in the same proportion that the number of FTE residents for that cost reporting period exceeds the number of FTE residents for the most recent cost reporting period ending on or before December 31, 1996. Hospitals that are part of the same affiliated group may elect to apply the limit on an aggregate basis. The fiscal intermediary may make appropriate modifications to apply the provisions of this paragraph (g)(4) based on the equivalent of a 12-month cost reporting period.

(5) For purposes of determining direct graduate medical education payment, for the hospital's first cost reporting period beginning on or after October 1, 1997, the hospital's weighted FTE count is equal to the average of the weighted FTE count for the payment year cost reporting period and the preceding cost reporting period. For cost reporting periods beginning on or after October 1, 1998, the hospital's weighted FTE count is equal to the average of the weighted FTE count for the payment year cost reporting period and the preceding two cost reporting periods. The fiscal intermediary may make appropriate modifications to apply the provisions of this paragraph based on the equivalent of 12-month cost reporting periods. If a hospital qualifies for an adjustment to the limit established under paragraph (g)(4) of this section for new medical residency programs created under paragraph

(g)(6) of this section, the count of residents participating in new medical residency training programs above the number included in the hospital's FTE count for the cost reporting period ending during calendar year 1996 is added after applying the averaging rules in this paragraph for a period of years. Residents participating in new medical residency training programs are included in the hospital's FTE count before applying the averaging rules after the period of years has expired. For purposes of this paragraph, the period of years equals the minimum accredited length for the type of program. The period of years begins when the first resident begins training.

(6) If a hospital establishes a new medical residency training program as defined in paragraph (g)(9) of this section on or after January 1, 1995, the hospital's FTE cap described under paragraph (g)(4) of this section may be adjusted as follows:

(i) If a hospital had no allopathic or osteopathic residents in its most recent cost reporting period ending on or before December 31, 1996, and it establishes a new medical residency training program on or after January 1, 1995, the hospital's unweighted FTE resident cap under paragraph (g)(4) of this section may be adjusted based on the product of the highest number of residents in any program year during the third year of the first program's existence for all new residency training programs and the number of years in which residents are expected to complete the program based on the minimum accredited length for the type of program. The adjustment to the cap may not exceed the number of accredited slots available to the hospital for the new program.

(A) If the residents are spending an entire program year (or years) at one hospital and the remainder of the program at another hospital, the adjustment to each respective hospital's cap is equal to the product of the highest number of residents in any program year during the third year of the first program's existence and the number of years the residents are training at each respective hospital.

(B) Prior to the implementation of the hospital's adjustment to its FTE

cap beginning with the fourth year of the hospital's residency program(s), the hospital's cap may be adjusted during each of the first 3 years of the hospital's new residency program using the actual number of residents participating in the new program. The adjustment may not exceed the number of accredited slots available to the hospital for each program year.

(C) Except for rural hospitals, the cap will not be adjusted for new programs established more than 3 years after the first program begins training residents.

(D) An urban hospital that qualifies for an adjustment to its FTE cap under paragraph (g)(6)(i) of this section is not permitted to be part of an affiliated group for purposes of establishing an aggregate FTE cap.

(E) A rural hospital that qualifies for an adjustment to its FTE cap under paragraph (g)(6)(i) of this section is permitted to be part of an affiliated group for purposes of establishing an aggregate FTE cap.

(ii) If a hospital had allopathic or osteopathic residents in its most recent cost reporting period ending on or before December 31, 1996, the hospital's unweighted FTE cap may be adjusted for new medical residency training programs established on or after January 1, 1995 and on or before August 5, 1997. The adjustment to the hospital's FTE resident limit for the new program is based on the product of the highest number of residents in any program year during the third year of the newly established program and the number of years in which residents are expected to complete each program based on the minimum accredited length for the type of program.

(A) If the residents are spending an entire program year (or years) at one hospital and the remainder of the program at another hospital, the adjustment to each respective hospital's cap is equal to the product of the highest number of residents in any program year during the third year of the first program's existence and the number of years the residents are training at each respective hospital.

(B) Prior to the implementation of the hospital's adjustment to its FTE cap beginning with the fourth year of the hospital's residency program, the

hospital's cap may be adjusted during each of the first 3 years of the hospital's new residency program, using the actual number of residents in the new programs. The adjustment may not exceed the number of accredited slots available to the hospital for each program year.

(iii) If a hospital with allopathic or osteopathic residents in its most recent cost reporting period ending on or before December 31, 1996, is located in a rural area (or other hospitals located in rural areas that added residents under paragraph (g)(6)(i) of this section), the hospital's unweighted FTE limit may be adjusted in the same manner described in paragraph (g)(6)(ii) of this section to reflect the increase for residents in the new medical residency training programs established after August 5, 1997. For these hospitals, the limit will be adjusted for additional new programs but not for expansions of existing or previously existing programs.

(iv) A hospital seeking an adjustment to the limit on its unweighted resident count policy must provide documentation to its fiscal intermediary justifying the adjustment.

(7) A hospital that began construction of its facility prior to August 5, 1997, and sponsored new medical residency training programs on or after January 1, 1995 and on or before August 5, 1997, that either received initial accreditation by the appropriate accrediting body or temporarily trained residents at another hospital(s) until the facility was completed, may receive an adjustment to its FTE cap.

(i) The newly constructed hospital's FTE cap is equal to the lesser of:

(A) The product of the highest number of residents in any program year during the third year of the newly established program and the number of years in which residents are expected to complete the programs based on the minimum accredited length for each type of program; or

(B) The number of accredited slots available to the hospital for each year of the programs.

(ii) If the new medical residency training programs sponsored by the newly constructed hospital have been in existence for 3 years or more by the

time the residents begin training at the newly constructed hospital, the newly constructed hospital's cap will be based on the number of residents training in the third year of the programs begun at the temporary training site.

(iii) If the new medical residency training programs sponsored by the newly constructed hospital have been in existence for less than 3 years by the time the residents begin training at the newly constructed hospital, the newly constructed hospital's cap will be based on the number of residents training at the newly constructed hospital in the third year of the programs (including the years at the temporary training site).

(iv) A hospital that qualifies for an adjustment to its FTE cap under paragraph (g)(7) of this section may be part of an affiliated group for purposes of establishing an aggregate FTE cap.

(v) The provisions of this paragraph (g)(7) are applicable during portions of cost reporting periods occurring on or after October 1, 1999.

(8) A hospital may receive a temporary adjustment to its FTE cap to reflect residents added because of another hospital's closure if the hospital meets the following criteria:

(i) The hospital is training additional residents from a hospital that closed on or after July 1, 1996.

(ii) No later than 60 days after the hospital begins to train the residents, the hospital submits a request to its fiscal intermediary for a temporary adjustment to its FTE cap, documents that the hospital is eligible for this temporary adjustment by identifying the residents who have come from the closed hospital and have caused the hospital to exceed its cap, and specifies the length of time the adjustment is needed.

(iii) For purposes of paragraph (g)(8) of this section, "closure" means the hospital terminates its Medicare agreement under the provisions of § 489.52 of this chapter.

(9) For purposes of paragraph (g) of this section, a new medical residency training program means a medical residency that receives initial accreditation by the appropriate accrediting

body or begins training residents on or after January 1, 1995.

(h) *Determination of weighting factors for foreign medical graduates.* (1) The weighting factor for a foreign medical graduate is determined under the provisions of paragraph (g) of this section if the foreign medical graduate—

(i) Has passed FMGEMS; or

(ii) Before July 1, 1986, received certification from, or passed an examination of, the Educational Committee for Foreign Medical Graduates.

(2) Before July 1, 1986, the weighting factor for a foreign medical graduate is 1.0 times the weight determined under the provisions of paragraph (g) of this section. On or after July 1, 1986, and before July 1, 1987, the weighting factor for a graduate of a foreign medical school who was in a residency program both before and after July 1, 1986 but who does not meet the requirements set forth in paragraph (h)(1) of this section is .50 times the weight determined under the provisions of paragraph (g) of this section.

(3) On or after July 1, 1987, these foreign medical graduates are not counted in determining the number of FTE residents.

(4) During the cost reporting period in which a foreign medical graduate passes FMGEMS, the weighting factor for that resident is determined under the provisions of paragraph (g) of this section for the part of the cost reporting period beginning with the month the resident passes the test.

(5) On or after September 1, 1989, the National Board of Medical Examiners Examination, Parts I and II, may be substituted for FMGEMS for purposes of the determination made under paragraphs (h)(1) and (h)(4) of this section.

(6) On or after June 1, 1992, the United States Medical Licensing Examination may be substituted for the FMGEMS for purposes of the determination made under paragraphs (h)(1) and (h)(4) of this section. On or after July 1, 1993 only the results of steps I and II of the United States Medical Licensing Examination shall be accepted for purposes of making this determination.

(i) To include a resident in the FTE count for a particular cost reporting

period, the hospital must furnish the following information.

The information must be certified by an official of the hospital and, if different, an official responsible for administering the residency program.

(1) The name and social security number of the resident.

(2) The type of residency program in which the individual participates and the number of years the resident has completed in all types of residency programs.

(3) The dates the resident is assigned to the hospital and any hospital-based providers.

(4) The dates the resident is assigned to other hospitals, or other free-standing providers, and any nonprovider setting during the cost reporting period, if any.

(5) The name of the medical, osteopathic, dental, or podiatric school from which the resident graduated and the date of graduation.

(6) If the resident is an FMG, documentation concerning whether the resident has satisfied the requirements of paragraph (h) of this section.

(7) The name of the employer paying the resident's salary.

(j) *Special rules for States that formerly had a waiver from Medicare reimbursement principles.* (1) Effective for cost reporting periods beginning on or after January 1, 1986, hospitals in States that, prior to becoming subject to the prospective payment system, had a waiver for the operation of a State reimbursement control system under section 1886(c) of the Act, section 402 of the Social Security Amendments of 1967 (42 U.S.C. 1395b-1 or section 222(a) of the Social Security Amendment of 1972 (42 U.S.C. 1395b-1 (note)) are permitted to change the order in which they allocate administrative and general costs to the order specified in the instructions for the Medicare cost report.

(2) For hospitals making this election, the base-period costs for the purpose of determining the per resident amount are adjusted to take into account the change in the order by which they allocate administrative and general costs to interns and residents in approved program cost centers.

(3) Per resident amounts are determined for the base period and updated as described in paragraph (e) of this section. For cost reporting periods beginning on or after January 1, 1986, payment is made based on the methodology described in paragraph (d) of this section.

(k) *Adjustment of a hospital's target amount or prospective payment hospital-specific rate—(1) Misclassified operating costs—(i) General rule.* If a hospital has its base-period graduate medical education costs reduced under paragraph (e)(1) of this section because those costs included misclassified operating costs, the hospital may request that the intermediary review the classification of the affected costs in its rate-of-increase ceiling or prospective payment base year for purposes of adjusting the hospital's target amount or hospital-specific rate. For those cost reports that are not subject to reopening under § 405.1885 of this chapter, the hospital's reopening request must explicitly state that the review is limited to this one issue.

(ii) *Request for review.* The hospital must request review of the classification of its rate of increase ceiling or prospective payment base year costs no later than 180 days after the date of the notice by the intermediary of the hospital's base-period average per resident amount. A hospital's request for review must include sufficient documentation to demonstrate to the intermediary that adjustment of the hospital's hospital-specific rate or target amount is warranted.

(iii) *Effect of intermediary's review.* If the intermediary, upon review of the hospital's costs, determines that the hospital's hospital-specific rate or target amount should be adjusted, the adjustment of the hospital-specific rate or the target amount is effective for the hospital's cost reporting periods subject to the prospective payment system or the rate-of-increase ceiling that are still subject to reopening under § 405.1885 of this chapter.

(2) *Misclassification of graduate medical education costs—(i) General rule.* If costs that should have been classified as graduate medical education costs were treated as operating costs during both the graduate medical education base

period and the rate-of-increase ceiling base year or prospective payment base year and the hospital wishes to receive benefit for the appropriate classification of these costs as graduate medical education costs in the graduate medical education base period, the hospital must request that the intermediary review the classification of the affected costs in the rate-of-increase ceiling or prospective payment base year for purposes of adjusting the hospital's target amount or hospital-specific rate. For those cost reports that are not subject to reopening under § 405.1885 of this chapter, the hospital's reopening request must explicitly state that the review is limited to this one issue.

(ii) *Request for review.* The hospital must request review of the classification of its costs no later than 180 days after the date of the intermediary's notice of the hospital's base-period average per resident amount. A hospital's request for review must include sufficient documentation to demonstrate to the intermediary that modification of the adjustment of the hospital's hospital-specific rate or target amount is warranted.

(iii) *Effect of intermediary's review.* If the intermediary, upon review of the hospital's costs, determines that the hospital's hospital-specific rate or target amount should be adjusted, the adjustment of the hospital-specific rate and the adjustment of the target amount is effective for the hospital's cost reporting periods subject to the prospective payment system or the rate-of-increase ceiling that are still subject to reopening under § 405.1885 of this chapter.

[54 FR 40316, Sept. 29, 1989; 55 FR 290, Jan. 4, 1990, as amended at 56 FR 43243, Aug. 30, 1991; 57 FR 39830, Sept. 1, 1992; 58 FR 46343, Sept. 1, 1993; 59 FR 45401, Sept. 1, 1994; 60 FR 63189, Dec. 8, 1995; 61 FR 46225, Aug. 30, 1996; 62 FR 46034, Aug. 29, 1997; 63 FR 26358, May 12, 1998; 63 FR 41005, July 31, 1998; 64 FR 41542, July 30, 1999]

§ 413.88 Incentive payments under plans for voluntary reduction in number of medical residents.

(a) *Statutory basis.* This section implements section 1886(h)(6) of the Act, which establishes a program under which incentive payments may be